HOUSE No. 1766

The Commonwealth of Massachusetts

77p.

II.

REPORT

OF THE

Mass. SPECIAL COMMISSION

TO

STUDY AND INVESTIGATE CERTAIN PUBLIC HEALTH MATTERS

UNDER CHAPTER 73 OF THE RESOLVES OF 1947

DECEMBER 3, 1947

BOSTON
WRIGHT & POTTER PRINTING CO., LEGISLATIVE PRINTERS
32 DERNE STREET
1948

The Commonwealth of Massachusetts

MEMBERS.

Appointed —

By the President of the Senate.

Sen. Richard H. Lee, Newton, *Chairman.*

By the Speaker of the House.

Rep. George W. Dean, Oakham, *Vice-Chairman.*
Rep. Joseph D. Rivest, Northampton.
Rep. Fred C. Harrington, Everett.

By the Governor.

Henry D. Chadwick, M.D., Waltham, *former Commissioner, State Department of Public Health.*

L. Jackson Smith, M.D., Springfield, *Commissioner of Public Health, Springfield.*

Curtis M. Hilliard, Wellesley, *Secretary to Commission and Supervisor, Board of Health, Wellesley and Weston.*

Consultant.

Charles F. Wilinsky, M.D., *Deputy Commissioner of Health, Boston.*

The Commonwealth of Massachusetts

REPORT OF THE SPECIAL COMMISSION ESTABLISHED TO MAKE A STUDY RELATIVE TO CERTAIN PUBLIC HEALTH MATTERS.

DECEMBER 3, 1947.

To the General Court of Massachusetts.

This Commission was authorized by chapter 73, Resolves of 1947, which provides as follows:

Resolved, That an unpaid special commission, to consist of one member of the senate to be designated by the president thereof, three members of the house of representatives to be designated by the speaker thereof, and three persons to be appointed by the governor, is hereby established to make a study relative to so much of the Governor's Address, printed as current senate document numbered one, as relates to the co-ordination of local, state and federal activities in the field of public health, and relative to the public health laws and policies of the commonwealth. Said commission shall also consider the subject matter of current house document numbered eighteen hundred and seventy, relative to the regulation of certain hospitals, sanatoria, convalescent and nursing homes by the department of public health. Said commission may expend for clerical and other services and expenses such sums as may be appropriated therefor. Said commission shall report to the general court the results of its study and its recommendations, together with drafts of legislation necessary to give effect to the same, by filing the same with the clerk of the house of representatives on or before the first Wednesday of December in the current year. *Approved June 28, 1947.*

I. ORGANIZATION.

In accordance with the authority delegated it, the Special Commission has studied and investigated certain public health matters and respectfully submits the following report: —

The Commission organized on September 18, 1947, at which time a Special Committee, consisting of Dr. Chadwick, Dr. Smith and Professor Hilliard, was established to prepare an agenda and direct attention to the more urgent problems to be considered.

It was the consensus of members of the Commission that, due to the limited time available for the study, the program be limited to a consideration of the more urgent phases of public health needs and problems as they exist, and that the activities of the Commission be directed towards a consideration of the following matters:

1. A study of the administrative organization and functions of the State Department of Public Health as relates to the co-ordination of local, state and federal activities in the field of public health.

2. The development of some equitable plan for the establishment of full-time health units throughout the Commonwealth in areas of such population as may be reasonably and economically administered.

3. The relocation of the Chronic Disease Hospital.

4. Consideration of the subject matter of House Document No. 1870 (1947) relative to the regulation of certain hospitals, sanatoria, convalescent and nursing homes by the Department of Public Health.

5. The question of introducing legislation requiring the X-ray examination of school teachers and other school employees.

Despite a limited budget and the short time allowed for deliberation on these subjects the Commission found it possible to hold seven meetings in Boston and one in Worcester. The study and investigation involved no out-of-state travel and the expenditures of the Commission were maintained well within the appropriation allotted.

The Commission was able to secure as their technical advisor, Dr. Carl E. Buck, Field Director of the American Public Health Association, who, with his assistant, Dr. Robert E. Rothermel, contributed invaluable aid and consultative advice to this Commission. Their report has been used as a guide in the deliberations of the Com-

mission and portions of it have been incorporated in the Commission's report on the phases relating to Local Health Practice and Administrative Reorganization of the Department of Public Health. The complete text of Dr. Buck's report is attached as a supplement, Appendix F.

The Commission wishes to acknowledge the able assistance and advice given by Dr. Charles F. Wilinsky as consultant to the Commission.

To Vlado A. Getting, Commissioner of Public Health, this Commission is indebted not only for giving so liberally of his own time but also for making available to its members the facilities of the Department of Public Health. In this respect we wish to thank especially Dr. Victoria M. Cass and Miss Dorothy A. Gullason.

The Commission voted to appoint certain technical committees to make a more thorough study of the subjects of local health and preventable diseases and in accordance with this vote the following committees were established: —

Technical Committee on Preventable Diseases.

Conrad Wesselhoeft, M.D., *Chairman*, Clinical Professor of Infectious Disease, Harvard School of Public Health.

John E. Gordon, M.D., Professor of Preventive Medicine and Epidemiology, Harvard School of Public Health.

David D. Rutstein, M.D., Charles Wilder Professor of Preventive Medicine and Epidemiology, Harvard Medical School.

Charles C. Lund, M.D., Assistant Professor of Surgery, Harvard Medical School.

Alton S. Pope, M.D., Dr. P.H., Deputy Commissioner, Massachusetts Department of Public Health.

Alfred Frechette, M.D., M.P.H., Director of Health Department, Brookline.

William L. Fleming, M.D., Associate Professor of Medicine, Boston University School of Medicine.

Technical Committee on Local Health.

Hugh R. Leavell, M.D., Dr. P.H., *Chairman*, Professor of Public Health Practice, Harvard School of Public Health.

Alfred L. Frechette, M.D., M.P.H., Health Officer, town of Brookline.

Ernest Morris, M.D., Health Officer, city of Newton.

Keble Perine, Health Officer, town of Belmont.

Robert E. Archibald, M.D., M.P.H., Massachusetts Department of Public Health.

Morris L. Lambie, Ph.D., L.H.D., Professor of Government, Graduate School of Public Administration, Harvard University.

Robert L. DeNormandie, M.D., Chairman, Board of Health, Lincoln.

II. Administrative Changes in the Department of Public Health.

Of primary consideration to the Commission was that portion of the Governor's message which charged us with the investigation of the policies and laws pertaining to public health. The Commission requested its technical advisor, Dr. Buck, to make an intensive study of the organization of the department and to prepare recommendations to the Commission relative to the simplification of the administrative organization.

As a result of the study and recommendations made by Dr. Buck in consultation with the Commissioner, the Commission recommends a simplification of the administration of the State Department of Public Health. At present there are eleven division directors and four bureau chiefs who are responsible directly to the Commissioner. This brings too heavy a burden upon the Commissioner and does not provide for a functional grouping of the various bureaus and divisions.

Accordingly a reorganization would —

(*a*) Enable the Commissioner of Public Health to administer his entire department through a small number of executive officers.

(*b*) Avoid a large number of independent administrative units and permit the Commissioner to correlate the work of the department more effectively.

(*c*) Define clearly the chain of responsibility of the directors of the several sections and divisions of the department.

(*d*) Centralize the administrative, not the technical or professional, direction of divisions and bureaus having close interrelationships by placing administrative re-

sponsibility in the office of a single section director, who in turn interprets the program and needs of these divisions and bureaus to the Commissioner.

(*e*) Provide a clear-cut channel to the field (local health units) through the section of local health service, for translating into effective local action the policies and techniques as worked out by the various divisions and bureaus and approved by the Commissioner of Public Health.

The Commission is in accord with the principles expressed in Dr. Buck's report relative to the simplification of the organization of the Department of Public Health. We particularly wish to comment upon the need for the appointment of assistant commissioners who may devote their entire time to the administrative duties in connection with the five sections, and to the recommendation that a reclassification of both titles and salaries of the professional personnel be made. Evidence collected by Dr. Buck clearly illustrates that the salaries paid professional personnel in Massachusetts cannot assure the people of Massachusetts of the necessary leadership to provide those basic public health services which are essential to the preservation of the health of the people either on a state or local level.

The Commission does not feel that it is necessary to further refer to Dr. Buck's report since it is attached. The Commission recommends that the principles in this report be adopted by the Department of Public Health and whenever applicable by other state agencies.

III. Local Health Services.

One of the major assignments of the Commission has been "to make a study relative to so much of the Governor's address, Senate Document No. 1, as relates to the co-ordination of local, state and federal activities in the field of public health, and relative to the public health laws and policies of the Commonwealth."

Perhaps the greatest need in public health in the United States and in the Commonwealth is the development of full-time adequately staffed local health departments for

population groups sufficiently large to enable efficient and economic administration of public health. At its meetings, the Commission has carefully studied the laws pertaining to the organization of local health departments and for unions of health departments, their duties, responsibilities and the services which they offer the people. Dr. Buck, our technical advisor some eleven years ago, made a survey of the Massachusetts Health Program and Policies, and this material has been used by the Special Recess Commission which reported its findings in House Document No. 1200 in 1936. Dr. Buck and his assistant, Dr. Robert Rothermel, were directed by this Commission to devote their time to the study of two aspects of public health practice: — (1) simplification of the organization of the State Department of Health, and (2) local health services.

Massachusetts may take pride in the fact that on the record of its vital statistics as relating to infant mortality, maternal mortality, the absence of smallpox from the Commonwealth, the low typhoid fever morbidity, the provision it makes for hospitalizing tuberculosis patients, and many other responsibilities, it compares favorably with other parts of the country. However, the Commission is not satisfied with just doing a good job — it wants to see the best possible public health program continue to evolve in Massachusetts. That it is not accomplishing all that it might is reflected in tables presented in the appendix in Dr. Buck's report which reveals that in the five-year period, 1941–1945, there were 1,583 deaths from what he calls preventable causes and over 70,000 from controllable causes. On the basis that preventable diseases are preventable and that those listed as controllable could be reduced by one half to one third, he estimates that 6,126 lives could be saved annually; representing, if we choose to evaluate lives in terms of $5,000 each, an annual saving of $30,630,000.

The expenditure of a relatively small amount of money for the development of local health departments would, to a large extent, bring about substantial savings of both lives and money. Experiences in Massachusetts and

throughout the nation have convinced the Commission that a definite program for the formation of local health departments must be developed, including legislation providing for their formation, their financial support and their establishment at as early a date as practicable.

The Commission has carefully studied the report prepared by its consultant, Dr. Buck, and the opinions presented by another consultant, Dr. Charles F. Wilinsky, and has conferred with public health administrators, state and local, in an effort to arrive at a definite plan for presentation to the Legislature.

The Technical Committee on Local Health before mentioned has been charged with developing a program for presentation to this Commission for the best methods for the organization and establishment of adequate full-time health departments serving a population of sufficient size so that services could be administered in an economical and efficient manner. Due to the pressure of time and the extent of the problem, this Technical Committee and the Commission have not been able to arrive at a conclusion as to the best method of making public health services available through local health departments to all the people in the Commonwealth. Much progress has been made but the work is not yet completed. The Commission wishes to study further the recommendations of its consultant, Dr. Buck, and wishes to continue to make further investigations and studies so as to be able to present at the next legislative session a definite program for the formation, support and establishment of local health units for the Commonwealth. This is one of the major needs of the people of the Commonwealth and we request the Legislature to authorize the continuation of these studies in an effort to find the best means of promoting health and saving the lives of the citizens of the Commonwealth.

Because of the complexity of the problem, and the need for a general popular understanding of the value and importance of modern public health services, the Commission recommends that the Central Health Council request His Excellency the Governor to appoint a chair-

man and co-chairman of a State-wide Health Committee as suggested in the report of Dr. Buck. This Committee should be composed of civic leaders and selected on a non-partisan basis and should have the authority to select a small executive committee who in turn would elect a permanent chairman, co-chairman and other officials. The committee would further organize by the appointment of additional members and perhaps form local branches. It is recommended that this State-wide Health Committee be established to sponsor and carry on an educational program, the first objectives of which should be to bring about an understanding of the need for and value of full-time, adequately staffed local health departments, an understanding which will result in turn in the formulation of legislation which will permit and facilitate the development of full-time health departments and which will assist in the actual establishment of such local health departments throughout the Commonwealth. It is further recommended that the Department of Public Health assign an executive secretary from its staff to assist the State-wide Committee, and that it make its facilities available to assist the committee in carrying on its program. It is specifically recommended that the Health Information Bureau of the Department of Public Health be expanded to assist in the dissemination of health information as authorized under section 5 of chapter 111, General Laws.

The Commission is convinced that some form of co-operative action between communities is essential for the formation of population groups of sufficient size to allow efficient and economical public health administration. This has been proved in the field of education. Massachusetts is one of the few states which is not at the present time making state tax funds available to local health departments to assist such public health units. Experience in Massachusetts and in other states indicates the need for increasing the salaries of the staffs of both local and state health departments, thereby improving the standards of health services.

The Commission has become aware of the comparatively low salaries paid to public health personnel in Massachusetts and wishes to emphasize the need for the better training of all health workers and the raising of educational standards and the general increase in the salary scales offered such workers upon entering a career in public health.

The Commission carefully reviewing Dr. Buck's report agrees in principle with the needs which he defines but finds time too short to give them complete consideration and wishes to continue its study and investigations of these needs during the coming year. The greatest needs in the formation of local health departments in Massachusetts at the present time are the following:

1. A sound state-wide program of education and health information which will bring about a universal understanding of the need and value of full-time health services.

2. Reinforcement of a strong State Department of Public Health since such a department must offer the leadership in the development of local health services.

3. Basic legislation permitting and facilitating establishment of full-time local health departments.

4. A plan for state financial assistance for the maintenance of full-time local health departments.

5. Adequate staff of well-trained full-time public health personnel.

6. Good salaries to attract qualified personnel.

7. The development of field training centers equipped to provide orientation for new state and local health department personnel.

8. The development of a method for measuring the accomplishments and needs of a community in the development of a public health program.

IV. Relocation of Chronic Disease Hospital.

The Commission received a request from His Excellency, Governor Robert F. Bradford, that the Commission "give particular consideration in their studies to

the projected chronic disease hospital." The Commission has made a study of the present legislation, chapter 511, Acts of 1946, authorizing the Department of Public Health to build an 800-bed hospital for chronic diseases and cancer, said hospital to be located at a site selected in Stoneham.

At the meetings of the Commission during October and November they carefully reviewed the existing legislation pertaining to this hospital, and, as a result of this study and information furnished to it by a study made by D. A. Muncy and A. T. Row of the Harvard School of Regional Planning entitled "A Location Study on the Proposed State Chronic Disease Hospital" (a copy of which is on file in the Department of Public Health), with further investigations and conferences with deans of medical schools, physicians and representatives of the Department of Public Health, determined that the present site at Stoneham was not suitable for the construction and efficient operation of a chronic disease hospital. It was found that, because of the nature of the terrain, approximately $350,000 would have to be expended for the blasting of stone prior to actual construction, and that the connections for water and sewage would require a further expenditure of $50,000. Thus while the Department of Public Health is being granted a site supposedly free of charge, it would in actuality have to expend $400,000 in order to make this site suitable.

Investigation further reveals that because of the remoteness of the site from either existing or planned extensions of the rapid transit system it would be necessary to build extensive housing facilities for personnel employed at the hospital; that it would require fifty to sixty minutes for a patient traveling by rapid transit from Park Street in Boston to reach the hospital, and that it would cost an extra fare for such transportation. Since many patients would be traveling from more distant places, a large amount of time would be expended in travel to and from the hospital (probably between three and four hours) which would discourage the average patient, or visitor,

from visiting the out-patient department or seeing a relative in the hospital. It was further revealed that the time required to travel by automobile from other hospitals in Boston, whose physicians would be wanted to serve on the staff of this chronic disease hospital, was between a half and three quarters of an hour. Thus, physicians would be driving approximately one to one and a half hours on each visit to the hospital, time which would be available for care of patients if the hospital were located near the medical centers.

As a result of its study and investigation the Commission concluded that the Department of Public Health, with the approval of the Governor and Council, should be authorized to purchase land in the city of Boston, such land being convenient to the public and to the profession serving the public, the site to be preferably within half an hour traveling time by rapid transit from Park Street, and within the ten-cent fare zone, and in the general section of Boston where other hospitals are located so as to make possible consultations and medical services by the staffs of these hospitals to patients at the chronic disease hospital.

Such a site, moreover, would make it unnecessary to build extensive housing facilities, and the savings resulting from the accessibility of water supplies and sewerage, and of a more suitable terrain, together with the economies of operation, would more than compensate for any reasonable cost of the site. In such a location the hospital would be much more accessible to the public and would, therefore, have a more active out-patient department. Thus patients who might otherwise require hospitalization could be taken care of more economically on an out-patient basis.

The Commission conferred with His Excellency, Governor Bradford, regarding the problem on October 30, 1947.

For these reasons the Commission recommends the enactment of the act shown as Appendix D.

V. The Licensing of Convalescent and Nursing Homes and Boarding Homes for the Aged.

In accordance with the directive of chapter 73, Resolves of 1947, this Commission considered House Documents Nos. 1870 and 1871 of the 1947 legislative session. A public hearing was held on October 14, 1947, at 2 P.M. in Room 448, State House. Invitations were sent to the Department of Public Welfare, Department of Public Health, and other interested persons to appear and present their views relative to the licensing of convalescent and nursing homes, and boarding homes for the aged. The following persons appeared before the Commission: Dr. Vlado A. Getting, Commissioner of Public Health; Dr. Richard P. MacKnight, Director of Hospital Licensing, Department of Public Health; Dr. Charles F. Wilinsky, representing the Massachusetts Public Health Association, the Public Health Council, and special consultant to this Commission; Miss Flora E. Burton, representing Mr. Patrick Tompkins, Commissioner of Public Welfare; Mr. Frank E. Wing, Director of the New England Medical Center and President of the Massachusetts Hospital Association; Dr. John Conlin, Director of Medical Information and Education of the Massachusetts Medical Society; Mrs. William Fuller, representing the Massachusetts Federation of Women's Clubs; and Miss Margaret Tracy, Executive Secretary of the Hospital Council of Boston.

The above persons appearing before the Commission declared their opinions relative to the importance of legislation requiring the licensing of convalescent and nursing homes and boarding homes for the aged. All agreed that such legislation was necessary and that a proper bill should be introduced in the coming legislature. With one exception they all were in agreement that the licensing of convalescent and nursing homes was a medical function; and that these institutions were essential accessories to hospitals in providing hospital, nursing and medical care to persons who were unable either to obtain hospital beds

because of overcrowding of hospitals, or who were unable to afford the higher cost of hospital care. Convalescent and nursing homes, it was agreed, furnish necessary care to patients who could more economically be taken care of in these institutions rather than in hospitals. It was pointed out by those testifying that the medical profession is desirous of protecting the public by assuring them that adequate minimum standards of nursing and medical care are provided to patients in convalescent and nursing homes.

The majority of those testifying indicated that in order to serve the public in the most efficient and economical way, and in order to avoid confusion and duplication of governmental procedures, it would be desirable to establish licensing of boarding homes for the aged in the same state agency responsible for the licensing of convalescent and nursing homes. Since individuals who are aged are prone to develop illnesses, it was the feeling of many of those testifying that boarding homes for the aged would frequently provide medical and nursing care for some of their occupants, and that while such homes should not necessarily have to conform in all respects with the requirements of convalescent and nursing homes, nevertheless, they should have some medical and nursing supervision to assure adequate provision for the care of any acute illness or emergency that may occur among the occupants.

One of the witnesses appearing in behalf of the Department of Public Welfare was convinced that boarding homes for the aged should be licensed by the Department of Public Welfare since more than half of the occupants were recipients of financial aid through local welfare departments. Testimony indicated that the Department of Public Welfare has been licensing boarding homes for the aged since 1929 and that revised regulations for boarding homes for the aged were prepared in 1947 but that these as yet have not been completely enforced. The Department of Public Welfare is, however, continuing its efforts to bring about improvement in the boarding homes for the aged.

Investigation of the Commission revealed that there are numerous convalescent and nursing homes for the aged and others which are not now licensed by any governmental agency. There is also reluctance on the part of many persons who may wish to go to, or to send their relatives to boarding homes for the aged when these homes hold a license issued by the Department of Public Welfare since this would imply that they, or their relatives, are thus recipients of charity. There are, of course, many boarding homes for the aged which do not provide care for any welfare recipients and yet under the law such homes must be licensed by the Department of Public Welfare.

The Commission met on October 30, 1947, and recommended to the Commissioner of Public Health that he and the Commissioner of Public Welfare and their staffs attempt to reach a mutually satisfactory resolution as to the proper method of licensing convalescent and nursing homes and boarding homes for the aged. On November 13, 1947, at a meeting in the State House, the Commission reviewed statements presented by the Commissioners of Public Health and Public Welfare which indicated that they had not come to an agreement because the Department of Public Welfare continued to be of the opinion that, inasmuch as over half of the occupants of boarding homes for the aged receive assistance from local departments of welfare, the Department of Public Welfare should license such homes. The Department of Public Health, on the other hand, maintained that convalescent and nursing homes were in reality medical and nursing institutions to which persons were admitted to receive such care, and that many such homes were not now being licensed by any governmental department. It argued that since the Department of Public Health has the responsibility of licensing all hospitals and clinics, exclusive of those taking care of mental patients, the licensing of this additional medical and nursing facility was properly a function which should be administered under physicians and nurses in the Department of Public Health and co-

ordinated with other licensing authority of the Department. It was pointed out that the demarcation of a hospital for the chronically ill and a large convalescent home must be defined and that this could best be accomplished only if the same agency licensed both establishments.

The Commission, after reviewing the testimony presented at its hearings, and other information made available to it, concluded that it was in agreement with an opinion expressed by the Ways and Means Committee, viz.: that every effort should be made to have the licensing of medical and nursing institutions as economical as possible and that these functions should be performed by a single state agency. It was also revealed that chapter 111 of the General Laws (Ter. Ed.) as amended by chapter 661 of the Acts of 1941, provided for the transfer from the Department of Public Welfare to the Department of Public Health the licensing of maternity hospitals and maternity wards at a time when the Department of Public Health was authorized to license hospitals. The Commission further determined that in many states the licensing of hospitals and convalescent and nursing homes is a function of the state department of health.

At a meeting of the Commission on November 20, 1947, held in Worcester, it was voted by the Commission that in the interests of economy and efficiency the authority for licensing convalescent and nursing homes and boarding homes for the aged should be vested in one department, and since medical and nursing care for acute or chronic illness is a problem in all such homes, and sanitation is of vital importance, that therefore the Department of Public Health is the logical agency to inspect and license all such homes.

The Commission recommends that the Department of Public Health consult with the Departments of Public Safety and Public Welfare in drawing up rules and regulations for the licensing of convalescent and nursing homes and boarding homes for the aged, and that the legislation require that prior to issuing a license to a

boarding home for the aged, the applicant be approved by the Department of Public Welfare, such approval to be limited to the character of the person to whom the license is issued and who is responsible for maintaining the boarding home for the aged. The Department of Public Health has been requested to draw up such rules and regulations for the licensing of convalescent and nursing homes and boarding homes for the aged, and to have them available for reference.

The Commission at this time wishes to express its gratitude to Mr. Patrick Tompkins, Commissioner of Public Welfare, for the time devoted to this subject by him and by members of his staff.

An act relative to the licensing of certain hospitals, sanatoria, convalescent and nursing homes and boarding homes for the aged by the Department of Public Health is herewith submitted.

VI. Examination of School Teachers.

House No. 1921, which was a bill introduced last year requiring the X-ray examination of teachers and other school personnel, failed of enactment. The bill would require an X-ray of the chest of all school employees who come in contact with school children and college students. The purpose of such an examination would be to prevent exposure to infectious cases of tuberculosis.

The States of Washington, Alabama, New Jersey and the city of New York have similar legislation. The law has been in effect in the State of Washington since 1940, and the state health commissioner has reported that it has worked very smoothly and already the incidence of infection among school children has declined. The school departments of 86 Massachusetts cities and towns now have regulations requiring chest X-ray examinations of school employees. The need for protecting pupils and students from contact with tuberculous teachers, lunchroom employees and bus drivers has been shown wherever these X-ray examinations have been made.

In a recent 5-year period, approximately 50 teachers in Massachusetts with active tuberculosis have been treated in our state and county sanatoria. At the close of World War II it was found that the number of cases of tuberculosis in the armed forces was only one tenth of that found in World War I. Medical officers believe that this difference was due largely to the exclusion of cases of tuberculosis by X-ray screening at the time of induction. About 1 per cent of the men examined at the induction centers were found to have evidence of tuberculosis. Chest X-ray examinations now suggested for teachers and other school personnel would provide this kind of screening and offer the students the same type of protection. The 24,000 teachers and 5,500 other school personnel in the public schools of Massachusetts and those who serve in similar capacities in the private schools and colleges should have chest X-ray examinations. These would be made without charge by the state, county and municipal sanatoria.

A bill similar to House No. 1921 should be re-introduced at a later time, but further study as to details may be made by the Technical Committee on Preventable Diseases who are to consider the whole subject of tuberculosis control.

RICHARD H. LEE.
CURTIS M. HILLIARD.
GEORGE W. DEAN.
FRED C. HARRINGTON.
JOSEPH D. RIVEST.
HENRY D. CHADWICK, M.D.
L. JACKSON SMITH, M.D.

PROPOSED LEGISLATION.

Appendix A.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Forty-Eight.

Resolve reviving and continuing the special commission on public health laws and policies and enlarging the scope of its investigation.

Resolved, That the unpaid special commission, established under chapter seventy-three of the resolves of nineteen hundred and forty-seven, is hereby revived and continued for the purposes specified in said chapter and for the purposes of extending the scope of their study in the investigations and studies relative to preventable diseases and to the establishment of full time local health units throughout the commonwealth. Said commission may expend for clerical and other services and expenses such sums as may be appropriated therefor. The final report of said commission shall be filed with the clerk of the house of representatives on or before the first Wednesday of December in the current year.

Appendix B.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Forty-Eight.

AN ACT FURTHER QUALIFYING THE TRAINING, EXPERIENCE, SALARY AND APPOINTMENT OF THE COMMISSIONER OF PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 2 of chapter 17 of the General Laws, as most recently amended by section 1, chapter 658, acts of 1947, is hereby further amended by striking out, in the first and second lines, the words "a physician skilled in sanitary science and experienced in public health administration" and inserting in place thereof the following words: - - a graduate of an approved medical school and an accredited school of public health with three years experience in a full time position in public health administration, or, in lieu of graduation from a school of public health, he shall have had at least five years experience in a full time approved position in public health; such experience shall have terminated not more than two years prior to the time such person is being considered for appointment.

SECTION 2. Section 2 of chapter 17 of the General Laws, as amended, is hereby further amended by inserting in the fourth line after the word "successor," the following words: — upon recommendation of the public health council.

SECTION 3. Said section 2 of chapter 17 of the General Laws, as amended, is hereby further amended by striking out, in the sixth line, the word "ten" and inserting in place thereof the word: — fifteen, — so that the last two sentences shall read as follows: — The commissioner shall receive a salary of fifteen thousand dollars. He shall be the executive and administrative head of the department.

Appendix C.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Forty-Eight.

AN ACT AUTHORIZING THE COMMISSIONER OF PUBLIC HEALTH TO DESIGNATE ONE OR MORE DEPUTY COMMISSIONERS.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Section 5 of chapter 17 of the General Laws is hereby amended by striking out, in the second and third lines, the words "a director of a division as a deputy commissioner," and inserting in place thereof the following words: — one or more deputy commissioners, — so as to read as follows: — *Section 5.* The commissioner may, with the approval of the public health council, designate one or more deputy commissioners, who shall perform the duties of the commissioner during his absence or disability and such other duties as may be prescribed by the commissioner.

Appendix D.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Forty-Eight.

AN ACT PROVIDING FOR THE CONSTRUCTION BY THE DEPARTMENT OF PUBLIC HEALTH IN THE CITY OF BOSTON OF A HOSPITAL FOR THE CARE OF PERSONS SUFFERING FROM CHRONIC DISEASES AND THE PURCHASE OF LAND THEREFOR.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The department of public health is hereby authorized and directed, with the approval of the governor and council, to purchase land in the city of Boston for a hospital of about eight hundred beds, for the care of persons suffering from chronic diseases, including a nurses' home, out-patient department and other necessary facilities and to construct thereon such a hospital and related facilities. For the purposes of this act, said department may expend for the purchase of the site and for the preparation of plans and construction of said hospital and related facilities any sums heretofore made available for the construction of such a hospital in the Stoneham section of the Middlesex Fells reservation and such

additional sums as may hereafter be made available for the purposes of this act.

SECTION 2. Chapter five hundred and eleven of the acts of nineteen hundred and forty-six is hereby repealed.

Appendix E.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Forty-Eight.

AN ACT RELATIVE TO THE REGULATION OF CERTAIN HOSPITALS, SANATORIA, CONVALESCENT AND NURSING HOMES AND BOARDING HOMES FOR THE AGED, BY THE DEPARTMENT OF PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 111 of the General Laws is hereby amended by striking out sections 71 to 73, inclusive, as amended, and inserting in place thereof the four following sections: —

Section 71. The department shall issue for a term of two years, and may renew for like terms, a license subject to revocation by it for cause, to any person whom it deems responsible and suitable to establish or maintain a hospital, sanatorium, convalescent or nursing home or boarding home for the aged which meets the requirements of the department established in accordance with its rules and regulations. In the case of an original application and an application for the renewal of a license, the local board of health shall first certify to the department, that from its inspection and examination of said hospital, sanatorium,

convalescent or nursing home or boarding home for the aged it is suitable for the purpose. In the case of a boarding home for the aged, the applicant shall be approved by the department of public welfare, such approval to be limited to the character of the person to whom the license is issued and who is responsible for maintaining the boarding home for the aged. Any person aggrieved by the refusal of the local board of health to certify as required above may in writing appeal to the department. The commissioner and the council, acting as the department, shall hold a public hearing and thereafter may modify, affirm or reverse the action of the local board of health. No license shall be issued or renewed hereunder unless there shall be first submitted to the department by the authorities in charge of the hospital, sanatorium, convalescent or nursing home or boarding home for the aged with respect to each building occupied by patients, a certificate of approval of the egresses, the means of preventing the spread of fire and the apparatus for extinguishing fire, issued by a building inspector of the department of public safety. Nothing in this section or in section seventy-two, seventy-two A or seventy-three, shall be construed to revoke, supersede or otherwise affect any laws, ordinances, by-laws, rules or regulations relating to building, zoning, registration or maintenance of hospitals, sanatoria, convalescent or nursing homes or boarding homes for the aged. Upon written request by an applicant who is aggrieved by the refusal to issue or renew such a license, or by a holder who is aggrieved by the revocation of such a license, as the case may be, the commissioner and the council shall hold a public hearing after due

notice and thereafter may modify, affirm or reverse the action of the department. In no case shall the revocation of such a license take effect in less than thirty days after written notification by the department to the hospital, sanatorium, convalescent or nursing home or boarding home for the aged. The fee for the issue or renewal of each license in the case of a hospital or sanatorium shall be twenty-five dollars and in the case of a convalescent or nursing home or boarding home for the aged shall be ten dollars and the license shall not be transferable or assignable and shall be issued only for the premises named in the application. For the purposes of this section and sections seventy-two, seventy-two A and seventy-three, a hospital or sanatorium is defined as any institution, however named, whether conducted for charity or for profit, which is advertised, announced or maintained for the express or implied purpose of caring for persons admitted thereto for the purpose of diagnosis or medical or surgical treatment which is rendered within said institution, except an institution caring exclusively for cases of mental diseases and licensed by, or under the general supervision of, the department of mental health. A convalescent or nursing home is defined as any institution, however named, whether conducted for charity or profit, which is advertised, announced or maintained for the express or implied purpose of caring for three or more persons admitted thereto for the purpose of nursing or convalescent care. A boarding home for the aged is defined as any institution, however named, which is advertised, announced or maintained for the express or implied purpose of providing care incident to old age to three or more persons over sixty years of age

who are not acutely ill or in need of medical or nursing care. Nursing institutions licensed by the department of mental health for mental cases shall not be licensed or inspected by the department of public health. Convalescent or nursing homes conducted in accordance with the practice and principle of the body known as the Church of Christ, Scientist, shall be inspected and licensed by the department for regulations pertaining to records and sanitation. The inspections herein provided shall be in addition to any other inspections required by law.

Section 72. The department shall classify all hospitals and sanatoria and shall promulgate rules for the conduct of the same. Such rules and regulations for hospitals and sanatoria shall include minimum requirements for diagnostic and therapeutic facilities for the study, diagnosis and treatment of patients, the keeping of proper medical records, and, in addition in the case of any maternity hospital or maternity service, such minimum requirements as are necessary for the identification and protection of infants born therein. The department shall further classify convalescent and nursing homes and boarding homes for the aged, and shall after a public hearing promulgate rules and regulations for the conduct of the same. In the case of boarding homes for the aged, said rules and regulations shall be promulgated after consultation with the department of public welfare. Such rules and regulations for convalescent and nursing homes and boarding homes for the aged shall include minimum requirements for medical and nursing care, the keeping of proper medical and nursing records and sanitation. The department or its agents and the board of health or its agents of the

city or town wherein any portion of such hospital, sanatorium, convalescent home or nursing home or boarding home for the aged is located may visit and inspect such institution at any time.

Section 72A. The department shall appoint an advisory committee on hospitals, sanatoria, convalescent and nursing homes and boarding homes for the aged to consist of representatives of the medical and nursing professions, hospital administrators and hospital trustees, who shall serve at the pleasure of the department, and two of such positions shall at all times be filled by persons appointed upon the recommendation of the Massachusetts Hospital Association. Said advisory committee shall also consist of ex-officio members composed of the commissioner of public welfare, the commissioner of mental health and the secretary of the Massachusetts emergency public works commission. Said committee shall advise the department in any matter pertaining to sections seventy-two, seventy-two A and seventy-three. Members of said committee shall serve without compensation, but shall receive the necessary traveling espenses incurred by them in the performance of their duties. Said committees shall meet not less than twice a year, and other meetings may be called by the department on proper notice.

Section 73. Whoever establishes or maintains, or is concerned in establishing or maintaining, a hospital, sanatorium, convalescent or nursing home or boarding home for the aged or is engaged in any such business, without a license granted under section seventy-one, or whoever being licensed under said section violates any provision of sections seventy-one to seventy-three, inclusive, or any rule or regulation

made under section seventy-two, shall for a first offence be punished by a fine of not more than five hundred dollars, and for a subsequent offence by a fine of not more than one thousand dollars or by imprisonment for not more than two years. Any convalescent home or nursing home or boarding home for the aged in existence on the effective date of this act for which an application for a license hereunder has been filed prior to one month after the effective date, may continue to operate during the period its application is under consideration without being deemed in violation of this act. Duplicate licenses shall be posted conspicuously for institutions maintained at separate premises, even though they are under the same management.

Appendix F.

REPORT TO THE SPECIAL COMMISSION ON PUBLIC HEALTH.[1]

In accordance with the decision of the Commission, made necessary because of the shortage of time, the consultant service herein reported upon has been confined to two major aspects of public health in Massachusetts, — the organization and administration of the Department of Health, and the development of some plan for the establishment and maintenance of full-time local health departments of sufficient population as to be susceptible of reasonably economic and effective administration.

The report will be presented in two parts.

PART I.

The Massachusetts Department of Public Health.

Massachusetts has a strong Department of Public Health. It has well-trained, capable, progressive and aggressive leadership. Its major activities are directed by well-trained, capable, professionally qualified personnel. The Department has an excellent *esprit de corps*. The Commonwealth has been and still is considerably ahead of most of the other States in such important activities as tuberculosis and cancer control, and in its supervision of water supply and sewage disposal systems.

Notwithstanding these basically important assets the Commonwealth still has some important unmet health needs.

[1] A report of consultant service rendered to the Commission by the American Public Health Association through its field staff, Carl E. Buck, Dr. P. H., Field Director, and Robert E. Rothermel, M.D., Assistant Field Director, November, 1947.

1. Massachusetts, in common with other New England States, is far behind most of the remainder of the country in developing full-time, adequately staffed, local health departments of sufficient population as to be susceptible of reasonably economic and effective administration.

2. Some activities still need to be established and some need further development. For example, the State Department of Health has not as yet developed any special activity in the field of accident prevention, which is one of our leading causes of death: the program of health education or health information, although good in special fields, should be so broadened as to be conducted on a state-wide basis, and so designed as to promote basic issues, such as full-time local health services; epidemiology, although well developed in the fields of the acute communicable diseases, tuberculosis, cancer and the venereal diseases, should be broadened to include the epidemiology of such causes of disability and death as accidents, diabetes, premature births, heart disease, etc.

3. There is a real need for the simplification of the plan of administration of the State Department of Health. Although there is a Deputy Commissioner of Public Health, he is from day to day the administrator of one of the major divisions of the Department, and functions as deputy only in the sense that when the Commissioner is absent he is the Acting Commissioner.

At present there are eleven division directors and four bureau chiefs who are responsible directly to the Commissioner of Public Health. There is no formalized method of co-ordinating the activities of these numerous divisions and bureaus except through the Commissioner himself. A nationally known business executive has said that no single executive can administer effectively more than five or six other executive officers if such other executives are carrying on activities of real scope and importance. Some simplified plan of organization which would facilitate effective administration is indicated.

4. There is an urgent need for more adequate salaries for persons professionally qualified in the field of public

health. Although nearly every State has a few well qualified persons who, because of loyalty, idealism, ownership of property or family ties, are willing to stay on their jobs in spite of inadequate salaries, the number is too small to fill even basically important positions. The number of vacancies in the State Department of Public Health bears mute testimony to the truth of this statement.

5. The method of appointing the State Commissioner of Public Health does not seem to be entirely sound. Although there is a State Health Council, the Governor may appoint the State Commissioner of Public Health without any reference to the wishes or recommendations of the Health Council.

6. The qualifications as prescribed for the State Commissioner of Public Health are not such as to assure the appointment of a truly qualified person.

The salary of the Commissioner of Public Health is prescribed by state legislation, and even at present, as in the past, is not commensurate with the importance of the duties and responsibilities placed upon such officer.

The most important basic weakness in the public health situation in Massachusetts — the lack of full-time adequately staffed local health departments — will be discussed at some length in Part II of this report. Full-time local health services will therefore not be dealt with at this point.

The following suggestions or recommendations are designed to simplify administration and strengthen the activities of the State Department of Public Health.

It is recommended: —

1. *Health Education.* — That the program of the Bureau of Health Education, or Health Information, be so broadened as to include a state-wide approach to such basic problems as the development of full-time local health services.

See also recommendation 2 in Part II of this report.

2. *Epidemiology.* — The excellent epidemiologic approach to such problems as the acute communicable

diseases, tuberculosis and cancer be extended to include epidemiologic studies in such fields as accidents, heart disease, diabetes, etc.

3. *Reorganization.* — That the State Department of Public Health be reorganized in accordance with the accompanying chart.

The several advantages of this plan of organization are:

(*a*) It enables the Commissioner of Public Health to administer his entire Department through a small number of executive officers.

(*b*) It avoids a large number of independent administrative units and permits the Commissioner to correlate the work of the Department more effectively.

(*c*) It defines clearly the chain of responsibility of the directors of the several sections and divisions of the Department.

(*d*) It centralizes the administrative, not the technical or professional, direction of divisions and bureaus having close interrelationships by placing administrative responsibility in the office of a single section director, who in turn interprets the program and needs of these divisions and bureaus to the Commissioner.

(*e*) It provides a clear-cut channel to the field (local health units) through the section of local health service, for translating into effective local action the policies and techniques as worked out by the various divisions and bureaus and approved by the Commissioner of Public Health.

Under this plan the Massachusetts Department of Health would consist of two branches, the State Health Council as the advisory, consultative, policy forming, but not executive branch, and the Commissioner of Public Health and his staff as the executive branch.

The executive branch, in addition to the Commissioner, would consist of five major sections, — those of General Services, Preventive Medical Services, Hospital and Medical Services, Environmental Sanitation, and Local Health Service. The various divisions and bureaus now existent or hereafter added would be allocated to the particular sections to which they would seem to belong.

Nothing in this recommendation should be construed as in any way decreasing the importance of any given activity or of interfering with the effective functioning of divisions or bureaus. It is merely a plan for simplifying administration and co-ordinating the efforts of activities with similar interests and objectives.

This plan can, we believe, be adopted without legislative action. It is a flexible plan in that it provides a means of promoting a few persons who have demonstrated exceptional administrative ability, or for the employment if indicated of new administrative personnel. For example, the placement of divisions in an over-all section to which they logically seem to belong provides a means of promoting to the position of section director any particularly capable administrator who may be found in these several divisions, also, under this plan, it is not necessary to make an immediate or permanent decision in appointing a section director.

Salaries based on Qualifications. — One point which should be clearly borne in mind by those in charge of administration and appointments, particularly the State Division of Personnel and the State Civil Service system, is that persons in charge of various activities should receive salaries commensurate with their professional qualifications of training, experience and demonstrated ability, and not solely in accordance with the plan of organization; for example, it is recommended that the section of Hospital and Medical Services be composed of at least the Divisions of Tuberculosis and Cancer Control, and General Hospital and Medical Services. The director of one or another of these Divisions might receive more remuneration than the others, or more than the director of the section, if his qualifications of training, experience and demonstrated ability warranted. A bureau chief might, if his qualifications merited it, receive a higher salary than a section or division director. While such instances would doubtless be the exception rather than the rule, we believe that the principle is important and should be understood and appreciated.

The chart endeavors to portray how vertical administration can be avoided and how the plans and policies of the Department as a whole can be translated into effective local action geared to meet local needs through the section of local health service.

Since the five section directors will occupy the principal administrative positions of the Department, it is recommended: —

4. *Deputy and Assistant Commissioners.* — That the five section directors be made assistant commissioners of public health, and that the Commissioner be permitted to designate one or more persons as deputy commissioners of public health.

General Services.

The section of General Services would include the Divisions and Bureaus of Business Administration, Health Education, Laboratories (including a Bureau of Research), Statistics and Records, Public Health Nursing, Medical Social Work, Nutrition, and Accident Prevention.

At first glance this grouping of apparently widely varying activities may seem strange. The common denominator is that they are general services, — services which are needed by and used by all other divisions and bureaus of the entire Department.

Business Administration. — Business Administration would include housekeeping, purchasing, personnel and fiscal affairs.

Health Education. — Health Education, or Health Information, as it is known at present, would not include all the health educational activities of the entire Department, but it would constitute the group of persons specially trained in this field, which group would be responsible for developing a broad over-all plan and for assisting other divisions and bureaus in developing their own programs of health education. Unfortunately no completely satisfactory term has, as yet, been developed for the functions of this group basically trained in educa-

tion but specializing in health. Some have suggested the term health extension agent. This, we believe, is apt to be confused with the excellent but quite different work being carried on by the extension departments of our state colleges of agriculture. Massachusetts and one or two other States use the title Health Information. Most States use Health Education, and the majority of persons specially trained in this field seem to prefer Health Education, although all admit that no designation, thus far suggested, seems entirely satisfactory.

Laboratories. — At present the State Department of Public Health has some eight laboratories, each separate and independent. There is the Biologic Laboratory, a functional entity unto itself, and not directly affiliated with any other activity. The Blood Plasma Laboratory is adjacent to the Biologic Laboratory and is a part of it. The Diagnostic Laboratory is an integral part of the Division of Communicable Diseases, and its chief is responsible to the Director of Communicable Diseases. The Water and Sewage Laboratories, of which there are three, including the Lawrence Experiment Station, are an integral part of the Division of Sanitary Engineering, and their chiefs are responsible to the Director of Sanitary Engineering. There are also two food and drug laboratories responsible to and a part of the Division of Food and Drugs.

Although it is fully recognized that nothing can be done immediately about this situation because of housing difficulties, it seems certain that, if and when suitable quarters are secured for the entire Department of Public Health, including all its divisions and bureaus, the various laboratories, with the possible exception of the Biologic Laboratory, can and should be merged into a single Division of Laboratories. That this is feasible is well attested to by experience in other States. If unusually spacious quarters, particularly with respect to grounds, are made available for the Department of Public Health, it would be feasible and desirable for the Biologic Laboratory to move along with the other laboratories. If this proves not to be the case the Biologic Laboratory should

remain where it is as a separate division. It is recommended: —

5. That as soon as suitable quarters for the entire Department of Public Health, including all its divisions and bureaus, are secured, its various laboratories, with the possible exception of the Biologic Laboratory, be merged into a single Division of Laboratories.

In contemplating such an amalgamation or merging of laboratories, which, we repeat, cannot, of course, be accomplished until adequate quarters for the entire Department are available, several points should be borne in mind:

(*a*) Each bureau of the Division of Laboratories should continue to have its technical, professional chief, and each bureau should continue to function as a service agency for the particular division to which its work applies. There would continue to be joint planning by the division directors and the chiefs of the several specialized laboratory services. Each division should be able to expect and obtain a greater volume of service and of equal quality to that possible under the present plan.

(*b*) There would be an over-all Division of Laboratories, with a well-qualified director. His function would be to co-ordinate and make the most effective use of available facilities and personnel. The greatest savings, and we believe that they would be considerable, would probably be effected in purchasing and in the more flexible use of sub-professional personnel, and certain equipment; for example, one laboratory usually has its peak load in the winter, another in the summer. Such a situation obviously presents very real possibilities in the more effective use of sub-professional personnel and certain equipment, such as dish sterilization.

Research. — Research is, and of course should be, carried on in all major activities. A very considerable amount of important research has been and is being carried on by the various divisions and bureaus of the Department of Health. Research is frequently retarded, and is sometimes less effective than would otherwise be

the case, because of the volume and pressure of necessary routine work. The situation is particularly acute in laboratory work.

It is therefore recommended —

6. That the proposed Division of Laboratories include a Bureau of Research.

Statistics and Records. — At present there is no division or bureau of either statistics or records. Each division and bureau maintains is own statistics and records. In Massachusetts, Vital Statistics, births, deaths, marriages, etc., are received, filed, tabulated and analyzed in the office of the Secretary of State. Because of the basic importance of this information to any state health department, there should be in the Department of Public Health a well-qualified person, whose principal duties should be to secure current information on births and deaths from the office of the Secretary of State. It is to be hoped that in the not too distant future Vital Statistics can and will be transferred to the Department of Public Health.

A considerable amount of valuable statistical work is carried on throughout the Department, but there is no centralization of record planning or of processing. Mortality, morbidity and service records, when analyzed and interpreted side by side, can be of inestimable value in defining problems, measuring progress in relation to these problems, and in future program planning.

Some of the information now being used is being hand tabulated, while some is mechanically tabulated. The chief value of mechanical tabulation, through the use of punch cards, is its simple portrayal of the relationship between many factors. Frequently information which does not involve the inter-relationship of several factors can be tabulated more readily and economically by hand.

In order that statistics and records may be utilized more economically and effectively, it is recommended —

7. That a Division of Statistics and Records be established and be directed by a person with both public health and statistical training and experience.

8. That the functions of the Division of Statistics and Records include the tabulation and analysis of all statistics and records of the entire Department, not only Vital Statistics, furnished by the office of the Secretary of State, but also morbidity records, service records of all divisions and bureaus, and records received by the Department from all other sources.

This recommendation is not intended to prevent other divisions or bureaus from setting up analyses which they may desire and need. It simply means that records would be processed by the Division of Statistics and Records and returned to the division or bureau to which they apply.

The analysis and interpretation of specific records may well involve conferences between the Division of Statistics and Records and the division or bureau to which the records apply.

Sufficient personnel to assure the prompt return of processed records is obviously essential. It is further recommended —

9. That no record forms in the Department be printed until they have been reviewed and approved by the Division of Statistics and Records.

The individual division or bureau will naturally indicate what information is desired. The Director of the Division of Statistics and Records can assist in the arrangement of the record form so as to facilitate tabulation and analysis, and it should be his prerogative to question the usefulness of each item which is proposed as part of the form.

Consultation service of the Division of Statistics and Records should be available to local health departments.

Public Health Nursing. — The proposed plans of reorganization would not affect public health nursing except that it would be transferred from local health administration to a co-ordinate service in the section of General Services.

One point is perhaps worthy of special mention. At present not all nurses in the employ of the State Depart-

ment of Public Health are members of Public Health Nursing. It is our conviction that all nurses in any Department of Health, whether they be graduate or public health nurses, should be members of the Division or Bureau of Public Health Nursing, regardless of where they are assigned administratively. It is therefore recommended —

10. That all nurses in the employ of the Department of Public Health be members of the Division of Public Health Nursing, regardless of where they may be assigned administratively.

Medical Social Work. — Medical social work would not be affected by the proposed reorganization except that it would be transferred from Local Health Administration to the section of General Services, and would be affiliated with other services with which it has close working relationships, such as public health nursing and nutrition.

Nutrition. — Nutrition would be affected to the same extent and in the same manner as medical social work.

Medical social work together with other special service functions, such as public health nursing, nutrition and sanitation, have been, in the proposed reorganization chart, transferred to other sections in the firm conviction that the principal function of the section of Local Health Service should and will become (as full-time local health departments are developed) essentially one of rendering consultation-advisory service on a generalized basis rather than one of furnishing either specialized or other direct services.

Accident Prevention. — At present no special activities are being carried on in the field of accident prevention. Since accidents represent one of the major causes of death, it would seem highly desirable that the Department of Public Health take cognizance of this fact in terms of some specific action. It is therefore recommended —

11. That a division or bureau of accident prevention be established, and that it be placed in the section of General Services.

The placement of accident prevention in the section of General Services is based on the premise that its services should be available to and be used by all the other divisions and bureaus of the Department. Regardless of where accident prevention is placed administratively, it would seem essential that there be close liaison between this service and the epidemiologist in charge of communicable diseases, since the ultimate solution of the problems of accident prevention rest on a sound epidemiologic approach. Such a division or bureau should devote its major efforts to the causes and prevention of home accidents, but should also endeavor to co-ordinate its activities with those of other agencies, such as police, fire, schools, housing, highways and the National Safety Council.

Preventive Medical Services.

The proposed section of Preventive Medical Services would include the Divisions of Disease Control, Maternal and Child Health, Public Health Dentistry, and the Venereal Diseases.

Disease Control. — The present service is designated as the Division of Communicable Diseases. The change to Disease Control is suggested in the thought that while the epidemiologist, in charge of the present Division, is officially responsible for only communicable diseases, he should co-operate with and give thought, counsel and advice to the services in maternal and child health, chronic disease control, accident prevention and environmental sanitation, since the ultimate solution of problems in these fields depends upon team work based upon a sound epidemiologic approach.

Maternal and Child Health. — The Division of Maternal and Child Health, including services for crippled children, would not be affected except that it would become a co-ordinate division of the section of Preventive Medical Services.

It is obvious that success in the field of maternal and child health will depend in no small measure upon effective working relationships between the Division of Maternal

and Child Health and other services of the Department, such as public health nursing, nutrition, medical social work, public health dentistry, tuberculosis, cancer and other chronic diseases, such as heart disease and diabetes, accident prevention, environmental sanitation, etc. The function of the section directors will be essentially to develop and strengthen these planning and working relationships.

Public Health Dentistry. — The Division of Public Health Dentistry would not be affected by the proposed reorganization, except that it would be placed as a coordinate service in the section of Preventive Medical Services. It is a relatively new division and its program is just beginning to make progress. The fact that Massachusetts had, according to selective service figures for the last World War, one of the highest rates in the country for dental caries, would seem to indicate a very real need for the development of a comprehensive dental health program.

The scope of the program is hampered inherently by a lack of personnel, dentists trained in children's dentistry, and, even more particularly, in the shortage of ancillary personnel, such as adequately trained dental hygienists and dental assistants.

The topical application of fluorine holds real hope of reducing substantially the incidence of dental caries.

In order to increase the scope and effectiveness of the dental health program it is recommended —

12. That every effort be made to increase the number of dentists who are willing to give, and capable of rendering, dental care to children, particularly very young children.

13. That facilities for providing adequately trained dental hygienists be substantially increased.

14. That the board of dental registration specifically permit the topical application of fluorine by dental hygienists under the supervision of registered dentists.

Venereal Diseases. — The reorganization plan would have, so far as one can foresee, no particular effect upon

the Division of Venereal Diseases unless it might bring about a closer liaison between the directors of epidemiology and the venereal diseases.

Hospital and Medical Services.

The proposed section of Hospital and Medical Services would consist of the Division of Sanatoria and Tuberculosis, and Cancer and Other Chronic Disease Control, and the Division of General Hospital and Medical Services.

Tuberculosis. — The Division of Sanatoria and Tuberculosis Control would not be affected by the new plan of organization, except, perhaps, to give it closer administrative alliance with the Division of Cancer and Other Chronic Disease Control.

Cancer. — The Division of Cancer and Other Chronic Disease Control would similarly not be affected by the proposed change, except to give its Director a somewhat more clearly defined administrative responsibility for the institutional aspects of cancer control.

As previously pointed out, there should be, as there are, close working relationships between the Epidemiologist in charge of Disease Control and the Directors of Tuberculosis and Cancer Control.

General Hospital and Medical Services. — The Division of General Hospital and Medical Services would include the functions involved in the administration of the Hospital Survey and Construction Act, the licensing of hospitals, and the licensing of convalescent and nursing homes, together with the licensing of homes for the aged, should such function be transferred to the Department of Public Health.

If, as time goes on, other activities in this field are developed, such as heart disease and diabetes, they may be added, as either divisions or bureaus, to this section of Hospital and Medical Services.

Environmental Sanitation.

The proposed section of Environmental Sanitation would include the Divisions and Bureaus of Sanitary

Engineering, Food and Drugs, General Sanitation, and the Experiment Station.

Sanitary Engineering. — The functions of the present Division of Sanitary Engineering would not be affected by the proposed plan, except that it would become a division of the section of Environmental Sanitation. As previously explained, the water and sewage laboratories would be transferred to the Division of Laboratories, if and when adequate housing facilities for the entire Department are procured, but would continue to function as service bureaus for the Division of Sanitary Engineering.

Food and Drugs. — The Division of Food and Drugs would be affected only to the same extent and in the same manner as the Division of Sanitary Engineering.

General Sanitation. — It is proposed to transfer General Sanitation from Local Health Service to the section of Environmental Sanitation, which unquestionably seems its logical place. As time goes on it is to be hoped that General Sanitation can give some attention to housing, rural accident prevention and to community planning, to meet problems of general sanitation, particularly in rural areas.

The Experiment Station. — The Experiment Station, which is the Lawrence Experiment Station, would not be affected in the proposed plan, except that its research functions should be facilitated by the establishment of the proposed bureau of research in the Division of Laboratories.

Local Health Service.

The primary functions of a state department of health are —

(*a*) To develop broad public health plans and policies for the State as a whole, avoiding such detail as would tend to make it difficult to take into consideration local interests, needs and potentialities, in their local application.

(*b*) To translate these state-wide, broad plans and policies into effective local action wherever possible

through full-time local health departments, reserving for direct service only those highly professional or technical services which are unfeasible or uneconomical of local procurement.

Functions of Sections and Divisions. — The functions of the section and division directors are —

(*a*) To develop broad plans and policies which when approved by the Commissioner become the plans and policies for the State as a whole as applied to public health.

(*b*) To render directly those services which cannot be carried on adequately locally; these should be reduced to a minimum.

(*c*) To furnish intensive field service to those areas in which the consultative-advisory field staff (hereafter to be discussed) has determined a need.

(*d*) To render emergency services only in areas without full-time health departments.

(*e*) To administer the functions referred to.

Functions of Local Health Service. — The functions of the section of Local Health Service are —

(*a*) To render such consultative-advisory field service as will assist local health departments in translating the broad plans and policies of the State Department of Public Health into effective local action, taking into full consideration local interests, needs and potentialities. In short, this is a service designed to bring about local health programs balanced to meet local problems and needs.

(*b*) To co-operate with the Division of Health Education in the development of a program of health education designed to promote the establishment of full-time health departments in areas not now covered by full-time service, the boundaries of health jurisdictions to follow an economical predetermined plan.

The most important needs of the entire state health program, in the opinion of the surveyors, are for a strong, well-developed section of Local Health Service, with a strong Division of Health Education as an important and necessary adjunct to this service.

Consultative Advisory Field Staff. — Local Health in the Massachusetts Department of Public Health at

present functions through the Division of Local Health Administration. In the proposed reorganization there would be a section of Local Health Service. The word "service" has been suggested rather than "administration," because its functions should become increasingly consultative and advisory rather than administrative.

At present, the Division of Local Health Administration assumes its responsibilities largely through its eight district health offices and their staffs. This system will necessarily have to be continued until such time as full-time, adequately staffed local health units evolve. When such local health units are a reality, it is recommended —

15. That a strong consultative-advisory field staff be established in the section of Local Health Service.

It is probable that this change from the present system of administration of Local Health Service to the one recommended above will be gradual. If this proves to be the case, then the replacement of the district health units by a strong consultative-advisory field staff would likewise be gradual.

The director of a section or division is appointed to that position because of his special training and experience in a particular field. As already stated, the principal function of the director of any service is to develop plans and policies in his or her specialty which, when approved by the Commissioner of Public Health, become the plans and policies of the Department. It is also his function to render directly, from the state level, those few services which cannot be carried on locally.

Basically, the essential function of the State Department of Public Health, with the advice and assistance of its sections and divisions, is to translate approved plans and policies into effective local action. To accomplish this, obviously there is need for field service. The administrative officers of the Department and the divisional directors and their associates are engaged mainly in developing plans and policies and in general administrative duties. There is little time available for field service.

The eventual evaluation of any state department of health depends largely upon its success in establishing or having established full-time local health departments maintaining continually progressive programs geared to meet local needs.

In order to give continuous periodic field service to all full-time local health units, there must be a group of professionally trained persons in the field constantly, — persons who have no central office duties other than to attend periodic conferences. In order to prevent an imbalance of local program it would seem entirely logical to place this field staff under the administration of the section whose particular function it is to translate departmental plans and policies into effective local action balanced to meet local needs — namely, the section of Local Health Service.

The primary objective in establishing such a consultative-advisory field staff is to bring about a more effective relationship between the State Department of Health and local health units through planned periodic visitation by professionally trained personnel, and emphasizing balanced local programs by obtaining a complete composite picture of strengths and weaknesses of a local program.

The minimum personnel for such a consultative-advisory field staff should consist of —

(*a*) A person particularly well trained in general public health administration, preferably a former county or city health officer, but in any event a person with broad administrative experience.

(*b*) One or more well-trained public health nurse advisors.

(*c*) One or more public health engineers or sanitarians with superior qualifications.

(*d*) At least one or more well-trained statistical clerks or record analysts.

To this group might well be added a representative in health education, perhaps a nutritionist, and possibly a public health dentist. It will be noted that this mini-

mum contemplated personnel does not represent specifically some of the various phases of public health, such as epidemiology, maternal and child health, laboratories, tuberculosis and venereal diseases. While there would seem to be no objection to adding such representatives, they have been omitted in the thought that since the primary objective of this service is to bring about a co-ordinated and balanced program, the public health administrator should be able to observe the general interest in and adequacy of programs in venereal diseases, tuberculosis, etc.

The public health administrator should have no assignment to any division and should be responsible solely to the Director of the section of Local Health Service.

The staff for the field service should be recruited, if possible, from the present employees of the Department, who have had broad experience in local units including supervisory responsibility. They will, of course, have to have demonstrated qualities of leadership.

In thinking of the development of this field service, one should bear in mind the fact that local health officers and other local health personnel will welcome periodic visitations, only providing the personnel in the field staff has adequate professional training and experience, and providing, further, that the approach of such service is on the basis of a co-ordinated balanced program rather than one of special interest of pressure groups.

It should also be borne in mind that this is by no means all the field service which is to be rendered by the Department of Health. In the first place, this field service is for the benefit of full-time health areas. Secondly, in spite of the fact that it has to some extent specialized trained observers, it is a generalized service designed to render periodic rather than intensive service, and to make possible a composite picture or diagnosis of strengths or weaknesses, interest or lack of interest, which will point the way for more intensive field service where such is needed.

This means, then, that field personnel *other* than members of the Consultative-Advisory Field Staff have four distinct functions:

(*a*) To render those direct services which cannot be rendered adequately by the local department.

(*b*) To give field service in unorganized areas which are unable to carry on generalized balanced programs.

(*c*) To render service specifically requested by local health departments.

(*d*) To furnish intensive field service in those areas and in those fields in which the composite diagnosis of the Consultative-Advisory Field Staff has indicated a need.

It should be emphasized again that the Consultative-Advisory Field Staff is not designed to encompass the entire field service; it has specific purposes as briefly outlined in preceding paragraphs.

Although the field staff as such would have no specific functions in unorganized areas, the general public health administrator of the staff plus a well-trained representative of health education do have an important function to perform in such areas.

Their function, after first having determined the specific areas susceptible of local health service development among the present unorganized areas, is to develop a program designed to bring about full-time health departments in such areas. This obviously requires a basic and perhaps relatively long-term program of health education, involving, first, a study of health problems, facilities and needs of the proposed health area, and second, the development of a sound permanent plan for meeting these needs, which is the establishment of a full-time health department. The rôle of the health educator in the program is to stimulate local groups or agencies to undertake self-studies of health problems and needs, and later to develop a plan for their solution. The rôle of the public health administrator is to assist in supplying basic data essential to the study, to interpret

the study to the group or groups undertaking it, and later to explain how a full-time local health department can be established.

In order to provide smoothly effective relationships between the section of Local Health Service and the other divisions of the Department, with maximum benefit to local health services, it is advisable to adopt the following policies and procedures:

(*a*) Personnel on the field staff should be top-notch people and should be acceptable to all divisions concerned.

(*b*) Field schedules for each member of the field staff should be prepared a month in advance and copies sent by the Director of Local Health Service to the other section and division directors.

(*c*) Field personnel must not advocate or approve change of policies or techniques approved by the Department. If a change seems desirable in a certain area, the suggested change must be discussed with the division director to whom the policy applies, and with the Director of the section of Local Health Service.

(*d*) The entire Consultative-Advisory Field Staff should report in the central office for regularly scheduled conferences, at least monthly or oftener in the developmental stages of the program. Such conferences should be attended by the field staff, Director of the section of Local Health Service and a good representation from other sections and divisions. The latter will vary with the scheduled program. The central office staff will be consultants to the field staff, and the latter will be invaluable to the policy-making group in reporting actual field problems and practices. The conferences should be the keystones of program planning on both state and local level.

(*e*) A report system must be devised based on experience and need. The reports should be made to the Director of the section of Local Health Service and routed by him to other section and division directors to whom the information is pertinent.

In order to bring about simplified and effective administration in accordance with the plan briefly described in preceding pages, it is strongly recommended —

16. That every effort be made to secure, at the earliest possible time, a suitable building of sufficient size to house the entire State Department of Public Health.

At present the various activities of the State Department of Public Health are housed in eleven different places. That such a situation makes administration extremely difficult can hardly be refuted. It is further recommended:

17. That a manual of procedure for the State Department of Public Health be published embodying the plan of organization and defining both administrative and functional responsibilities.

18. It is also recommended that all administrative personnel, section, division and bureau directors, be invited to attend regularly scheduled staff conferences of the Department.

Additional staff conferences limited to certain persons may well be held, but we believe that at least a reasonable number of regularly scheduled staff conferences should be open to all administrative personnel. Interdivision or interbureau staff conferences of services having interlocking relationships are often profitable, such as, for example, public health nursing, medical social work and nutrition.

It is further recommended:

19. *Salaries.* — That the State Division of Personnel review its present plan of classifications and salary schedules for public health personnel, and that it consider the recommendations concerning public health classifications and salary schedules as given in Appendix A.

It is our conviction that this is a basically important recommendation to the future of public health progress in Massachusetts.

It is further recommended:

20. That present legislation pertaining to the appointment, the qualifications and the salary of the Commissioner of Public Health be amended so as to provide:

(*a*) That the Commissioner of Public Health be appointed by the Governor for a five-year term of office on the recommendation of the State Health Council.

(*b*) That to be eligible for appointment as Commissioner of Public Health a person must be a graduate of an approved medical school and of an accredited school of public health, and have had at least three years' experience in a full-time position in public health administration. In lieu of curricular work in public health he shall have at least five years' experience in a full-time position in public health administration. Such experience should have been terminated not more than two years prior to the time such person is being considered for appointment.

(*c*) That the salary of the Commissioner of Public Health be $15,000 per annum.

PART II.

Full-Time Local Health Services.

While the Commonwealth of Massachusetts has been and still is far ahead of most of the other States in such important activities as cancer and tuberculosis control, and in its supervision of water supply and sewage disposal systems, Massachusetts, in common with other New England States, is far behind most of the remainder of the country in developing full-time adequately staffed local health departments of sufficient population as to be susceptible of reasonably economic and effective administration.

Practically all public health administrators are agreed that today the most important public health need through-

out the United States is for complete coverage, with adequately staffed full-time health departments of sufficient population to be administered economically and effectively. This is unquestionably the greatest public health need in Massachusetts.

Not more than four health departments in Massachusetts would be judged "good" on the basis of generally accepted standards.[1] Notwithstanding, there are perhaps a great many people in this Commonwealth who are satisfied with the situation as it exists. Why? Simply because Massachusetts rates for preventable causes are somewhat better than the average for the country as a whole. This is being satisfied rather easily, because it is well known that the rates for the country as a whole can be greatly reduced.

Let us examine one segment of the situation here in Massachusetts.

The following table gives the deaths from certain causes in Massachusetts for the five-year period 1941–1945:

Preventable Causes.		*Controllable Causes.*	
Diphtheria	50	Cancer	37,361
Measles	71	Tuberculosis	7,888
Whooping cough	142	Lobar pneumonia	3,962
Syphilis	1,238	Premature births	4,696
Smallpox	0	Accidents	14,670
Typhoid fever	20	Meningo-meningitis	279
Bacterial dysentery	26	Scarlet fever	63
Tetanus	29	Maternal deaths	934
Undulant fever	7	Diarrhea and enteritis (under two years)	693
Total	1,583	Total	70,546

If the knowledge which is already at hand were universally applied throughout the Commonwealth, the saving in lives would be tremendous. All of the deaths from preventable causes could have been avoided, and it is very conservatively estimated that at least one half of all the deaths from controllable causes, except cancer,

[1] The Evaluation Schedule of the American Public Health Association, 1947 Edition, 1790 Broadway, New York, N. Y.

and at least one third of the cancer deaths, could be prevented. Altogether this would mean a saving of 30,630 lives, or an annual saving of 6,126 lives.

Even if a human life were worth as little as $5,000 this would mean a saving of $153,150,000, or an annual saving of $30,630,000.

Bearing in mind these savings, would it not be worth a very real effort to enact legislation which would permit and facilitate the development of full-time health departments, and later to provide modest appropriations for their support, if such health departments with their component community health programs can, and we know that they can, bring about such important savings?

It should be borne in mind that the figures given represent but a segment of the picture; they take no account of the sickness, suffering and huge economic losses which result from the incidence or prevalence of these causes which do not result in death.

If full-time local health departments constitute the greatest public health need in the country as a whole, as well as in Massachusetts, what are the basic essentials to their establishment and maintenance?

The basic essentials to effective local health services are:

(*a*) A sound state-wide program of health education or health information which will bring about, as nearly as possible, a universal understanding of the need for and value of full-time local health services. We should all know what a good health department can mean to us and to our families.

(*b*) A strong State Department of Public Health. It has been our observation that seldom does the level of local health service rise above the level of health leadership and planning as exemplified in the State Department of Health. Not infrequently, however, local health services lag far behind state leadership and planning.

(*c*) Basic legislation permitting and facilitating the establishment of full-time local health departments.

(*d*) Some plan of state subsidy for the maintenance of full-time local health departments. Various factors con-

tribute to the necessity for state subsidy. In some instances, local tax limitations make it impossible to raise sufficient local funds for maintaining adequate local health services. Sometimes the contemplated area of health jurisdiction is too poor, even without tax limitations, to raise the necessary funds, and in some instances the health problems are of such magnitude as to make impossible complete local financing. Experience seems to indicate that no State can, under its present tax structure, attain or maintain complete coverage with full-time local health services without some plan of state financial aid.

(*e*) Adequate staffs of well-trained public health personnel to man full-time health units.

(*f*) Good salaries for qualified public health personnel. The attainment of the basic essential just mentioned — adequate staffs of well-trained persons — cannot be accomplished without good salary scales. This statement applies to both state and local health departments. That this is true is well attested to by the situation throughout the United States. Only in those comparatively few States where decent salaries are paid is it possible to recruit and retain in service qualified personnel. The recruitment and retention in service of good people depends upon, first and foremost, good salaries; second, reasonable tenure of office; third, opportunity for advancement; and fourth, some reasonable plan of retirement. These requisites are usually effected through a well-conducted merit or civil service system.

(*g*) One or several training centers equipped to provide orientation for newly employed state or local health department personnel and to furnish in-service training for persons already employed. Of the several requisites for a good training center, the most important is that it be a strong, well developed, adequately staffed local health department, preferably one embracing both urban and rural populations. Quite apart from its teaching functions, which are, of course, basically important, such a strong local health department serves as the best possible demonstration of what can be done to improve local

health protection and health promotion services. Such a unit or units will prove to be of inestimable value in promoting the establishment of other full-time health departments.

(*h*) Evaluation or stocktaking. As soon as feasible after a local health department has begun to function, an analysis and evaluation of assets and liabilities should be undertaken. Such evaluation should include the facilities and programs of the entire community, not merely those of the health department. This can best be done through the use of the Evaluation Schedule of the American Public Health Association,[1] which is the only generally recognized measuring rod for local health services. Such an evaluation has many uses, among the more important of which are: it provides a base from which to measure future progress; it calls attention to achievements and unmet needs (based on generally accepted standards rather than personal judgment); and it furnishes a firm foundation for a program of health education and for future program planning.

Let us examine very briefly the situation in Massachusetts in relation to these basic essentials for effective local health services.

(*a*) Massachusetts has done and is doing some excellent work in health education, but it has been in special fields, such as school health, tuberculosis, cancer control, etc. The Commonwealth has never, however, developed a sound state-wide program of health education or health information designed to achieve a real understanding of what full-time local health services can mean to you and to me and our families.

(*b*) Massachusetts does have a strong State Department of Public Health. It has trained, capable leadership; its major activities are directed by well-trained, capable, professional personnel; and it has an excellent *esprit de corps*. Some activities need further development. The Department, because of a lack of full-time local

[1] The Evaluation Schedule, 1947 Edition, the American Public Health Association, 1790 Broadway, New York, N. Y.

health departments, is rendering more direct service than would otherwise be justified. There is need for a simplification of administration, and a very urgent need for more adequate salaries.

(*c*) Basic legislation permitting and facilitating the establishment of full-time local health departments. Legislation already enacted contains two acts which specifically concern the formation of local health departments. One permits cities to abolish executive boards of health in favor of full-time health departments, the other permits towns to combine to form health unions. Although the first act has been used in a few instances, the second act has been used in only two instances, and in both of these instances only when outside funds were available. Neither of these acts have had any far-reaching effect in promoting or facilitating the development of full-time, adequately staffed local health departments. Perhaps part of the difficulty lies in the lack of comprehensiveness of the acts themselves, but the failure is probably largely due to the lack of a sound state-wide program of health education designed to achieve the objective of full-time local health departments.

(*d*) Massachusetts is one of the few States which does not appropriate any state tax funds for the development of full-time local health departments. As previously stated, experience seems to indicate that no State can, under its present tax structure, attain or maintain complete coverage with full-time local health services without some plan of financial aid. The Massachusetts Department of Public Health does, because of the lack of full-time health departments, render more than its share of valuable direct services to local areas. These services, plus a superior corps of medical practitioners, plus an above-average intelligence quotient, have tended to keep the health record of the Commonwealth somewhat better than the national average.

While there will always be a need for planning and consultative advisory service from the State to local areas, the vast majority of public health administrators

are agreed that direct services from the State should be reduced to a minimum; that they are expensive; and that, with a few exceptions, they can usually be more acceptably and more effectively administered through local full-time health departments. Massachusetts' reasonably good health record has been accomplished in spite of poor administrative principles. Its health record could, we are convinced, be substantially improved by the establishment of recognized administrative principles.

(*e, f*) Adequate staffs of qualified personnel and good salaries are so interdependent that they should be considered together. Obviously, both state and local health departments need adequate staffs of qualified personnel. The State Department of Health has a considerable number of vacancies which are due to inadequate salaries. The number of full-time local health departments is small, but even so, not infrequently it has been impossible to fill positions because of inadequate salaries. Massachusetts is not one of the States with good salaries for public health personnel.

As already mentioned, there are some very well-qualified, capable public health persons in Massachusetts which at first glance might seem to refute the statements made concerning the inadequacy of salaries. In any State there will always be a few well-qualified persons who are either idealists, or have family ties, or have property which make them willing to stay on their jobs in spite of inadequate salaries. This number, however, is altogether too small to supply the demand for trained personnel, and the problem becomes increasingly acute as more and more full-time health departments are established.

(*g*) There are no training centers in Massachusetts capable of training the several groups of professional public health personnel. One of the real difficulties in establishing an adequate training center is due to the fact that at present there is no full-time health department embracing both urban and rural populations.

(*h*) Because of the scarcity of full-time local health departments, there has been a limited use of the evalua-

tion process in Massachusetts. However, a few of the better developed health departments have made rather consistent use of the Evaluation Schedule.

In order to meet the basic essentials for the establishment and maintenance of full-time local health departments of sufficient population to be reasonably, economically and effectively administered, it is recommended:

1. That a state-wide health committee be established to sponsor and carry on an educational program, the first objectives of which should be to bring about as nearly as possible a universal understanding of the need for and value of full-time adequately staffed local health departments, — an understanding which will result in (*a*) the passage of legislation which will permit and facilitate the development of full-time local health departments, and (*b*) the actual establishment of such departments.

As a means of establishing such a state-wide health committee, it is further recommended:

2. That the Massachusetts Central Health Council request the Governor to appoint a chairman and co-chairman of a state-wide health committee, preferably one a man and the other a woman, and that they — the chairman and co-chairman — be permitted to appoint their own executive committee, and that the executive committee in turn appoint chairmen and co-chairmen of various local affiliated committees.

Such a plan would avoid any thought that the committee was to be the Governor's committee or a committee of the Central Health Council.

While no rule of thumb can be applied, it would seem advisable that the chairman and co-chairman be simply well-known prominent people — people whose opinions would be respected, and that they *not* be thought of as representing any special group, political organization, profession or agency.

The executive committee may range from a dozen to forty members, depending upon the wishes of the chair-

man and co-chairman. This group, the executive committee, should be largely or substantially lay in character, but should probably include representatives from such groups as the State Health Council, the Central Health Council, and the medical, dental, engineering and nursing professions. Other representatives may be indicated (depending somewhat on who are selected from the groups already mentioned), such as the State Tuberculosis Association, the State Legislature, labor, the Parent-Teacher Association, the School of Public Health, the medical schools, the State Department of Education, the clergy and the newspapers. All of these do *not* necessarily have to be represented on the executive committee. If all groups or organizations interested in health were represented the number of the executive committee would be unwieldy.

The executive committee having selected chairmen and co-chairmen for local affiliated committees, these chairmen and co-chairmen should assume responsibility for organizing their own affiliated county or district health committees.

If the make-up of the executive committee is such as to make it feasible, it might be desirable to ask each member to assume responsibility for following through on the formation of local affiliated committees in his own neighborhood.

While, as previously stated, no rule-of-thumb method may be applied to either the formation or program of such a state-wide health committee, with its affiliated local committees, a few general guiding principles may be worthy of consideration:

(*a*) The state-wide health committee should be a self-initiated and self-perpetuating committee quite independent of any governmental or other agency.

(*b*) The committee should be organized on the premise that it is to be essentially a citizens' committee representing non-partisan lay interest, *not* a group representing vested interests.

(*c*) The committee has no legal or official status and no specific authority, but is rather a group dedicated to self-

studies of the Commonwealth's public health facilities, problems and needs — in short, to studies of its assets and liabilities as related to public health, with the development of suggested ways and means of overcoming such liabilities as are found to exist.

(*d*) The committee should look to and be able to rely upon the official health agencies for supplying factual information.

(*e*) After studies have been pursued to a point where professional interpretation is desired, the committee should be able to rely upon some professionally trained public health persons from the State Department of Public Health (or if the study be in an area with a full-time health department, upon a representative of the local health department) to furnish such professional interpretation.

(*f*) The State Department of Public Health, or some other health agency, should be in a position to loan the full time, or a large part of the time, of a secretary to the committee to carry on necessary correspondence, arrange for meetings of state and local groups, furnish factual data, arrange for professional interpretation when such is desired, and keep records of committee transactions, and perhaps edit and distribute such bulletins and news letters as the committee may wish to issue.

(*g*) It is to be hoped that the State Department of Public Health or some other organization may be able to set aside a modest fund to defray the travel expenses of the chairman or co-chairman, or other member of the executive committee in attending meetings of local committees.

(*h*) The principal major objective of the state committee should be the development of a widespread understanding of the need for and value of full-time, adequately staffed local health departments. The principles, or basic essentials for obtaining adequately staffed, full-time local health departments will, we hope, be clearly defined in this report, and should, therefore, provide a reasonable guide for the initial major efforts of the statewide health committee and its local affiliates.

(*i*) As full-time local health departments are developed, the local committees of the area covered by the local health unit should, of course, work in close co-operation with the local health unit, and look to it for professional interpretation and guidance.

(*j*) It is quite possible that, particularly in the organizational phases of the program, for the sake of convenience in holding meetings, it would be wise to group certain areas into districts or regions and hold general meetings on this basis.

It is further recommended:

3. That the Bureau of Health Information of the State Department of Public Health offer its assistance to and work in close co-operation with the proposed state-wide health committee.

The major efforts of the Bureau of Health Information may well be devoted to assisting the state-wide health committee and its local affiliated committees. On the other hand, the bureau of Health Information should assist but not attempt to dominate or chart the course of action of the committee.

A Strong State Health Department. — As already mentioned, Massachusetts does have a strong State Department of Public Health. Some activities need further development; there is need for a co-ordination and simplification of administrative organization, and an urgent need for more adequate salaries. (See recommendations in Part I, the State Department of Public Health).

Basic Legislation. — Present legislation seems to lack the comprehensiveness necessary to facilitate the development of full-time local health departments of sufficient population to be reasonably, economically and effectively administered.

It is therefore recommended:

4. That legislation be enacted which will include the following provisions:

(*a*) That the county commissioners of any county be authorized, if they so desire, to establish a full-time county health department.

(*b*) That the county commissioners be authorized to appropriate funds for the maintenance of such full-time county health departments.

(*c*) That, if general funds which can be appropriated for the maintenance of a county health department are insufficient, the county commissioners be authorized to place before the voters the question of whether or not to tax themselves in an amount not to exceed one mill per each $1 of assessed valuation for the maintenance of a full-time county health department. Such tax, if levied, may be, if necessary, in addition to any statutory tax limitation.

(*d*) That if for any reason it proves unfeasible to levy a millage tax, the county board of health (hereafter to be recommended) and the county health officer should prepare a budget for the operation and maintenance of the county health department, and present it to the county commission which in turn would present the budget to the State Legislature.

(*e*) That because of their small populations, it should be possible, upon the favorable vote of their respective county commissioners, for the counties of Barnstable, Dukes and Nantucket to form a single tri-county health department.

(*f*) That, if the county commissioners vote to establish a county health department, municipalities of 50,000 or more population (according to the last report of the U. S. Census Bureau) may elect to become an integral part of the proposed county health department or to maintain their own full-time health departments; provided, however, that if such a municipality decides to maintain its own health department, such department must meet the minimum qualifications of personnel, salaries and program which the State Department of Public Health is hereby authorized to establish. Municipalities whose populations range from 40,000 to 50,000 may petition the State Department of Public Health to establish or maintain their own full-time health departments, and if approved, may establish or maintain such departments.

(*g*) That, if a municipality of 50,000 or more population decides to maintain an approved health department of its own, such municipality shall be exempt from such special public health tax as may be assessed in such county.

(*h*) That whenever the county commissioners of any county agree to establish a county health department, the chairman of the county commission should, within a month of the time such agreement has been reached, call a meeting of all the local boards of health within the proposed health area. As soon as the meeting is called to order, the several boards of health should elect a chairman of the meeting. This having been done, the chairman should call for nominations of persons to serve on the county board of health. The number of nominations should not be less than fifteen nor more than thirty. As soon as the nominations are closed, a written ballot should be taken, and the five persons receiving the greatest number of votes shall be declared to be elected as the county board of health; provided, however, that no two members shall be elected from the same municipality; and further provided, that no single professional or other group shall constitute a majority of the board. Each member of a local board of health should vote for ten names in order to avoid the possibility of electing among the five highest more than one person from a single municipality, or electing a majority from a single professional or other group. If two persons from the same community are among the five persons receiving the greatest number of votes, the person with the lesser number of votes shall be dropped and the person receiving the sixth highest number of votes shall be declared elected. The same principle should apply in case the five persons receiving the highest number of votes should include more than two from any single professional or other group. The persons receiving the highest number of votes should be declared elected for a five-year term, the next highest

for a 4-year term, the next for three years, the next for two years and the fifth for a one-year term. All subsequent elections or re-elections should be for five-year terms. If a member of the board resigns or dies, the other members of the board shall make a temporary appointment, the appointment to hold until the next annual or other meeting of the various local boards of health whose municipalities are represented in the county or district health department. The county board of health should meet at least quarterly and at such other times as may seem advisable on the call of the president.

(*i*) That if a municipality of 50,000 or more population decides to join the county health department, such municipality may, through its mayor or city council, appoint (in addition to the five members) a member of the county board of health. Such member should be appointed for a five-year term, and at the end of such term be subject to reappointment or replacement at the discretion of the mayor or city council.

(*j*) That a county health department may, by a majority popular vote, be abolished at any time after five years of its establishment.

(*k*) That any municipality of 50,000 or more population which has joined a county health department may, by a majority popular vote, abolish its participation in such county health department at any time after five years after joining such health department. However, if such municipality elects to terminate its participation in the county health department, it shall establish its own full-time health department, meeting the minimum standards of personnel and program, as established by the State Department of Public Health.

(*l*) That the county health officer be appointed for a five-year term of office by the county board of health; provided, however, that he must meet the minimum qualifications for such position as established by the State Department of Public Health. The county

health officer may be reappointed or replaced at the discretion of the board. The county health officer may be removed at any time for just cause. The county health officer may act as secretary of the board of health, but he should not be a member of the board.

(*m*) That the county department of health should consist of two branches, the board of health as the advisory, consultative, policy-forming branch, and the health officer and his staff as the executive branch. The board of health should not have administrative authority.

(*n*) That the board of health should have the authority, on the recommendation of the health officer, to pass such rules and regulations as it deems necessary for the protection and promotion of the public health. Such rules and regulations should have the effect of law, provided they are not in conflict with existing state legislation or rules and regulations of the State Department of Public Health. The county board of health should adopt the rules and regulations of the State Department of Health as they apply to the prevention and control of communicable diseases. All other rules and regulations of the county board of health may be more stringent, but not less stringent than existing state legislation or rules and regulations of the State Department of Public Health.

(*o*) That the county health officer should be the executive and administrative officer of the county health department and should appoint other personnel of the Department; provided they meet the minimum qualifications for such personnel as established by the State Department of Public Health and are approved by the county board of health.

(*p*) That nothing in this act should be construed as abrogating the authorities and functions of local boards of health and local health agents, except that the county board of health shall be the senior board of health for the area of health jurisdiction, and shall, in cases of dispute, make final decisions. Similarly, the

county health officer shall be the senior health officer of the area of health jurisdiction (which would, of course, be exclusive of municipalities of 50,000 or more population which elect to maintain their own full-time health departments), and shall plan the basic health functions for the area of health jurisdiction.

(*q*) That nothing in this act shall be construed as preventing municipalities from transferring the authorities and functions of their local boards of health and health agents to the county board of health and the county health officer, if they so desire. If such transfer is made the local board of health would continue to function in the annual election of the county board of health, and in carrying on, or arranging for carrying on, such functions as would not be considered proper functions of a county health department, such as garbage and refuse disposal. Such functions might well be transferred to another agency.

(*r*) That all reportable diseases and conditions be reported either to the county health department or to the nearest branch of such county health department. Local boards of health or health agent offices would be designated as branch offices of the county health department. In some of the larger counties it may be feasible and desirable to have one or more branch health centers staffed by personnel of the county health department.

(*s*) That the health officer of any county should be responsible for observing such rules and regulations as may from time to time be promulgated by the Massachusetts Department of Public Health, and should make such reports as may be required by such Department.

(*t*) That the county board of health should be authorized to negotiate with the State Department of Public Health for such financial assistance for the operation and maintenance of the full-time county health department as the State Department of Public Health may be able to provide through state and

federal funds. (It is recommended that the allocation of funds from the State Department of Public Health to local full-time health departments be made on the combined basis of population, ability of the local area to meet its governmental financial needs, and the importance of local health problems. Except where the local area is quite evidently unable to meet its governmental needs and/or local health problems are of pressing importance, the contribution of local funds should be from 50 per cent upward of the total full-time local health department budget.)

It is fully appreciated that the legislation proposed in the preceding sections places no compulsion upon any unit of government. It simply makes it possible for the properly constituted authorities to act if the people want them to act. This philosophy is based on the premise that sound public health progress is seldom achieved by compulsion or compulsory legislation, but rather by a sound program of health education or health information.

Attention should be called to the fact that this proposed plan for county health departments does not interfere with the existing legislation which permits towns to co-operate in forming health unions.

State Subsidies for Local Health Departments. — As a necessary means of establishing full-time local health departments which will provide adequate health services throughout the State, it is recommended that legislation be enacted which will provide:

5. That the Commonwealth of Massachusetts make an appropriation to the State Department of Public Health of $2,000,000, and such other sums as may from time to time be necessary to be used to assist financially in the operation and maintenance of full-time approved health departments. Not over 5 per cent of such appropriation should be used for administration. At least 95 per cent of such appropriation should be allocated to such full-time health departments as meet the minimum qualifications, with

respect to personnel, salaries and program, as are established by the Massachusetts department of public health. Funds should be distributed in accordance with a formula or criteria to be developed by the state department of public health. Qualifications for personnel should apply only to persons employed after such qualifications are established.

Adequate Staffs of Qualified Personnel, paid Good Salaries. — That adequate staffs of qualified personnel are necessary for effective health services can hardly be disputed. There are a number of requisites for the recruitment and retention in service of qualified personnel, the most important of which is good salaries. Other important essentials are reasonable tenure of office, opportunity for advancement, and some equitable plan of retirement.

6. That local health departments, which are given state or federal subsidies, be required to meet the minimum standards regarding qualifications and salary scales as established by the Department of Public Health. Local health jurisdictions may exceed the minimum requirements, but should not be less than those established by the State Department of Public Health for qualifications and salaries.

Training Centers. — As soon as county health departments are established in reasonable numbers it is recommended:

7. That one or more full-time health departments be designated by the State Department of Public Health as training centers, to provide orientation for newly employed state or local health department personnel, and to furnish in-service training for personnel already employed. Areas designated as training centers should receive additional funds for carrying out its training functions.

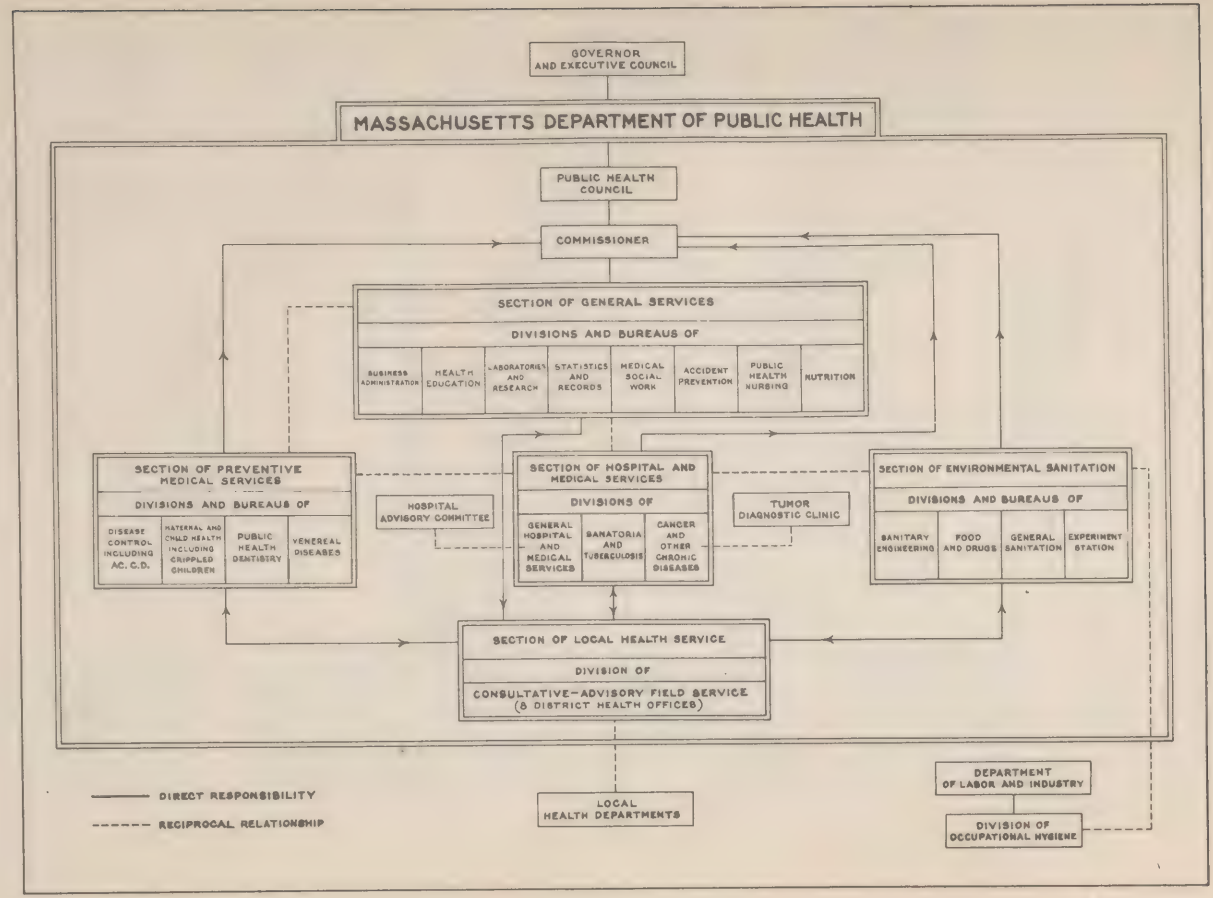
Evaluation. — No business would fail to evaluate its assets and liabilities, yet many health departments seem

to feel that this principle does not apply to health facilities and programs. Community health constitutes big business, and should be as carefully scrutinized and evaluated as any other big business. The Evaluation Schedule of the American Public Health Association, as stated previously, is the generally recognized measuring rod for local health facilities and programs.

It is therefore recommended:

8. That all full-time health departments, as soon after their establishment as possible, — not over one year, — take stock of their assets and liabilities through the use of the Evaluation Schedule of the American Public Health Association, or some similar schedule, as a sound basis for establishing a base line from which to measure future progress, calling attention to achievements and needs (based on generally accepted standards rather than personal judgment), and furnishing a sound foundation for a program of health education and for future program planning.

It is firmly believed that the objective of this section — Part II Full-Time Local Health Services — can and will be achieved if there is a well-planned, state-wide program of health education such as that described in the discussion of the proposed state-wide health committee. Similarly it is our firm conviction that it would be folly to introduce such legislation as has been proposed in this report until such a health educational program has been carried on for a considerable period of time.


GOVERNOR AND EXECUTIVE COUNCIL
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH COUNCIL
COMMISSIONER
SECTION OF GENERAL SERVICES
DIVISIONS AND BUREAUS OF
BUSINESS ADMINISTRATION
HEALTH EDUCATION
LABORATORIES AND RESEARCH
STATISTICS AND RECORDS
MEDICAL SOCIAL WORK
ACCIDENT PREVENTION
PUBLIC HEALTH NURSING
NUTRITION
SECTION OF PREVENTIVE MEDICAL SERVICES
DIVISIONS AND BUREAUS OF
DISEASE CONTROL INCLUDING A.C.D.
MATERNAL AND CHILD HEALTH INCLUDING CRIPPLED CHILDREN
PUBLIC HEALTH DENTISTRY
VENEREAL DISEASES
HOSPITAL ADVISORY COMMITTEE
SECTION OF HOSPITAL AND MEDICAL SERVICES
DIVISIONS OF
GENERAL HOSPITAL AND MEDICAL SERVICES
SANATORIA AND TUBERCULOSIS
CANCER AND OTHER CHRONIC DISEASES
TUMOR DIAGNOSTIC CLINIC
SECTION OF ENVIRONMENTAL SANITATION
DIVISIONS AND BUREAUS OF
SANITARY ENGINEERING
FOOD AND DRUGS
GENERAL SANITATION
EXPERIMENT STATION
SECTION OF LOCAL HEALTH SERVICE
DIVISION OF
CONSULTATIVE-ADVISORY FIELD SERVICE
(8 DISTRICT HEALTH OFFICES)
DIRECT RESPONSIBILITY
RECIPROCAL RELATIONSHIP
LOCAL HEALTH DEPARTMENTS
DEPARTMENT OF LABOR AND INDUSTRY
DIVISION OF OCCUPATIONAL HYGIENE

APPENDIX 1.

Proposed Classification and Salary Schedules.

Public Health Physician.

Grade I	$6,300–$7,560
Grade II	6,900– 8,280
Grade III	7,200– 8,640
Grade IV	7,500– 9,000
Grade V	9,500–11,500
Grade VI	13,000–15,000

Public Health Engineer.

Grade I	3,900– 4,680
Grade II	4,500– 5,400
Grade III	5,100– 6,120
Grade IV	6,600– 7,920
Grade V	8,000– 9,000
Grade VI	9,000–11,500

Public Health Dentist.

Grade I	5,100– 6,120
Grade II	6,600– 7,920
Grade III	8,000– 9,000

Public Health Bacteriologist or Chemist.

Grade I	2,400– 2,880
Grade II	3,300– 3,960
Grade III	3,900– 4,680
Grade IV	4,800– 5,760
Grade V	5,700– 6,840

Public Health Nurse.

Grade I	2,400– 2,880
Grade II	2,700– 3,240
Grade III	3,600– 4,320
Grade IV	3,900– 4,680
Grade V	5,700– 6,840

Business Administrator.

Grade I	3,600– 4,320
Grade II	3,900– 4,680
Grade III	5,700– 6,840

Graduate Nurse.

Grade I	$2,360–$2,600
Grade II	2,560– 2,920
Grade III	2,760– 3,240
Grade IV	3,240– 3,960
Grade V	3,960– 4,320

Health Educator.

Grade I	2,400– 2,880
Grade II	2,700– 3,240
Grade III	3,600– 4,320
Grade IV	4,500– 5,400
Grade V	5,700– 6,840

Public Health Statistician.

Grade I	2,700– 3,240
Grade II	3,000– 3,600
Grade III	4,500– 5,400

Public Health Nutritionist.

Grade I	2,700– 3,240
Grade II	3,000– 3,600
Grade III	4,500– 5,400

Sanitarian.

Grade I	3,300– 3,960
Grade II	3,900– 4,600
Grade III	4,500– 5,400
Grade IV	5,100– 6,120

Medical Social Worker.

Grade I	2,400– 2,880
Grade II	2,700– 3,240
Grade III	3,600– 4,320
Grade IV	4,500– 5,400

Venereal Disease Investigator.

Grade I	2,400– 2,880
Grade II	2,700– 3,240

X-ray Technician.

Grade I	2,400– 2,880
Grade II	2,700– 3,240

Public Health Veterinarian.

Grade I	4,500– 5,400
Grade II	5,100– 6,120

Health Records Consultant.

Grade I	$2,400–$2,880
Grade II	2,700– 3,240

Secretary to the State Health Officer.

Secretary to the state health officer	3,000– 3,600

Dental Hygienist.

Grade I	2,400– 2,880
Grade II	2,700– 3,240

It is recognized that this list is not all-inclusive, but it does, we believe, include the more important professional entities to be found in the modern public health program. If this plan of title classifications and salary ranges is to operate successfully, it is essential that persons with more than minimum qualifications in any given classification be employed at more than the minimum salary, and that salary increases be granted on the basis of demonstrated ability and not solely on a time factor.